Full Legal Name:	DMH State ID#:	DOB

Individual Rights
I have been presented the individual rights material from the Missouri Department of Mental Health, and have had any questions answered. My signature on this plan certifies an understanding of my rights as an individual, or guardian of an individual supported by the Department of Mental Health's Division of Developmental Disabilities.

Medicaid Waiver Rights: *Statement applicable_____ Statement not applicable_____*
As a participant in the Medicaid Waiver, I understand that I have the right to appeal any adverse decisions, including denial of participation in the Waiver, denial of authorization for a requested service, reduction of services or units of service without my written approval, and/or determination that I am no longer eligible for the Waiver. I may receive the assistance of my support coordinator or any other Regional Office staff in the appeals process. If an individual and/or responsible party timely files an appeal of a final decision, services currently being provided under an existing plan of care will not be suspended, reduced or terminated pending a hearing decision unless the individual or legal representative requests in writing that services be suspended, reduced or terminated. The individual and/or responsible party may be responsible for repayment of any federal or state funds expended for services while the appeal is pending if the hearing decision upholds the director's decision.

Abuse/Neglect
I understand that any person receiving supports and/or services has the right to be free from abuse, neglect, and exploitation. Abuse can be physical, verbal, mental, sexual, or financial in nature. Neglect is not getting the things a person needs to be healthy and safe. Exploitation means being taken advantage of or treated unjustly.

AUTHORIZATION AND APPROVAL SIGNATURES

This Individual Support Plan is an annual plan that represents an ongoing commitment to assisting the individual/family in addressing their support needs. This plan must be updated annually and reviewed at least quarterly to evaluate progress toward outcomes and to specify future supports needed. The plan may be revised at any time at the request of any of the parties listed below.

My signature below gives consent for the delivery of services addressed in this individual plan which implements on _____. No Regional Office funding is to begin until approval has been given by the Regional Director for new services or increased funding.

Signatures

_____ _____
Individual's Signature (If no guardian, this is authorizing signature) *Date*

_____ _____
Parent/Legal Guardian (authorizing signature for plan) *Date*

_____ _____
Support Coordinator (required signature) *Date*

_____ _____
Provider Representative (optional) *Date*

_____ _____
Other (optional-include relationship to individual) *Date*